



# Health Plan Services



THE COORDINATING CENTER  
INSPIRED SOLUTIONS

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## VISION

People of all ages and abilities have equitable access to achieve optimal quality health, affordable housing and meaningful community life.

## MISSION

The mission of The Coordinating Center is to partner with people of all ages and abilities and those who support them in the community to achieve their aspirations for independence, health and meaningful community life.



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## ABOUT US

The Coordinating Center is Maryland's premier, nonprofit care coordination organization, with vast experience in delivering community-based care coordination for people with disabilities, and the most complex medical and social needs. The Center holds URAC Accreditation in Case Management and is certified by Maryland Nonprofits Standards for Excellence.

Since 1983, The Coordinating Center has translated national movements into ground level, community-based programs centered on: population health, Medicaid rebalancing initiatives, aging in place, reducing avoidable hospital encounters and homelessness. The Coordinating Center has expertise in partnering to resolve complicated, intractable and costly social and health challenges for some of the state's most vulnerable populations. Working with people who have low incomes, high health utilization rates and/or disabilities, The Coordinating Center locates, coordinates and navigates services for more than 9,200 children and adults. Our innovative programs improve the health and quality of life for people transitioning from institutions, nursing facilities and hospitals to homes in the community of their choice, while reducing costs to the system and citizens of Maryland.



# HEALTH PLAN SERVICES

The Coordinating Center excels at complex care management services for members of Managed Care Organizations (MCOs) statewide, including children and adults with disabilities and/or multiple chronic conditions and frequent hospital encounters. For example, we work with children and adults (birth through age 64) who have high risk scores, two or more chronic conditions, rely on polypharmacy (eight or more medications), have had two or more hospital encounters within a six month time period, and medical challenges, such as lack of social support, a compromised emotional state and limited access to transportation.

## OUR IMPACT

The Coordinating Center has a proven track record of reducing health care cost and has consistently outperformed other contractors hired by other MCOs with demonstrated savings as high as \$2,000 per member/per month. This is attributed to an extremely knowledgeable care coordination team that excels at complex case management services, understands Value Based Purchasing, Total Cost of Care, as well as best practices in case management services according to the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC).

The Coordinating Center is certified by URAC case management accreditation, and has successfully participated in the NCQA Health Plan certification process three times over the past 14 years, meeting all requirements and standards. Additionally, The Coordinating Center recently achieved 100% passing score for MCO annual Delegation Audit.



## STAFFING

Care Teams at The Coordinating Center are led by licensed R.N.s, who help members avoid unnecessary hospital use, adhere to preventative health schedules and access vital clinical and community resources.

- Care Teams can be enhanced to include a Program Support Specialist and/or Community Health Workers to assist with administrative and scheduling support, as well as coordination of resources to address social determinants of health.
- To better support MCO Members, Care Teams generally live in the communities they serve.
- Our ratio of R.N. Care Coordinators to MCO Members is one to 25-30 Members.



# TECHNOLOGY

The Coordinating Center embraces the integration of new technology and care coordination, which are essential in better meeting client outcomes.

- Care Teams use a proprietary client management information system designed to capture activities related to care management, care coordination and care transition. This system, known as CARMA has interoperability with CRISP, Maryland's designated Health Information Exchange (HIE), enabling The Coordinating Center to respond to Electronic Notification System (ENS) alerts.
- Our Care Teams also have experience documenting in other Electronic Medical Health Record Systems, such as Epic and Cerner.

The Coordinating Center has a full-service Information Systems Department, a Quality, Improvement and Outcomes Management Department and staff trained in Health Informatics, which enable Care Teams to improve care, ensuring high quality and efficiency.

# HOW WE HELP

The Coordinating Center's Care Teams play an important role in the promotion of health and wellness, as well as removing barriers to accessing care.

- We collaborate with partners on member engagement to allow Care Management support for up to one year and provide ongoing care coordination if needed.
- We help MCO members navigate complex healthcare systems, maximize healthcare benefits and follow preventative health care schedules. At the same time Care Teams know how to leverage other Medicaid programs and waivers to meet long-term care needs.



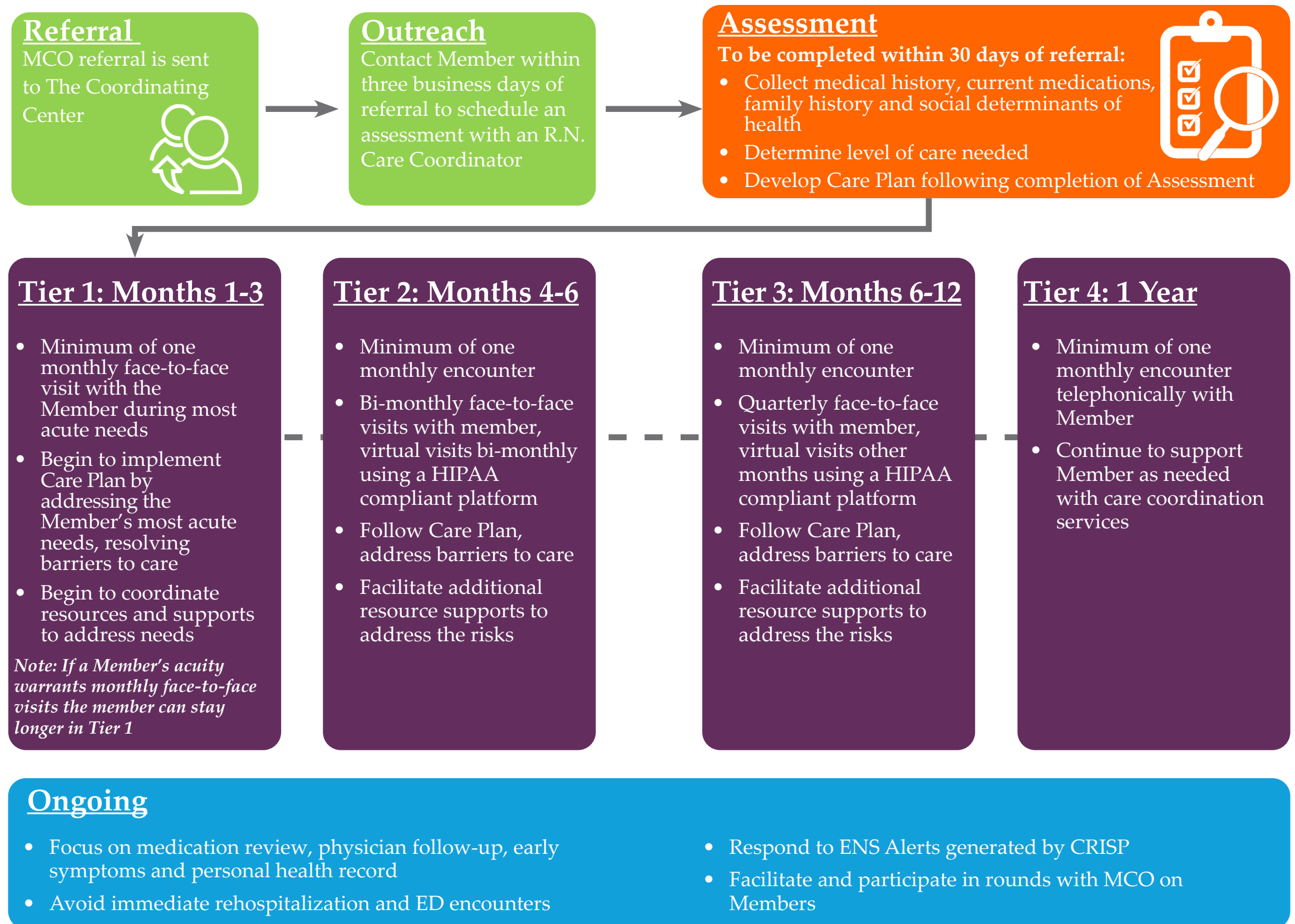
# WE HELP MEMBERS BY

- Meeting them **face-to-face** in their homes and in the community
- Educating them about their condition(s) and promoting self-management skills
- Maintaining preventative health schedules that meet **HEDIS** measures
- Focusing on medication review, physician follow up, early symptoms management and maintenance of a personal health record
- Ensuring communication with and among the medical home team is clear, frequent and timely
- Helping members handle issues that may keep them from getting **the right care, at the right time, and in the right place**
- Assisting with coordination and participation in medical appointments, as well as access to durable medical equipment and disposable medical supplies
- Helping members understand when to see their doctor rather than using the Emergency Department (ED)
- Explaining services, supports, and options available through **Medical Assistance** (Maryland Medicaid), Medicaid policies and procedures, as well as locating other non-Medicaid/ community resources to address Social Determinants of Health (SDOH)
- Guiding and facilitating member enrollment into supportive and **long-term support systems** within the State of Maryland
- Anticipating, planning and facilitating **transitions** (e.g., hospital to home, nursing facility to home, school-based services to adult services, including health care transition)
- Locating affordable and accessible housing, providing housing supports and training individuals in the area of good tenancy topics
- Helping coordinate personal attendant care providers to assist with activities of daily living (ADLs) or instrumental activities of daily living (IADLs)



# Sample of Complex Case Management Services Work Flow at The Coordinating Center

(Note: Can be customized to meet MCO requirements)





# PARTNER WITH US

The Coordinating Center is well positioned to partner with health care systems\* in achieving positive health outcomes for their members. In addition to healthcare priorities, our experienced Care Coordinators help people access a wide variety of public and private services and community resources while providing strategies to address the totality of a person's needs.

We deliver customized care management services including care coordination and care transition services that meet the specific needs. The Center has the experience and expertise needed to quickly and effectively roll out and implement a program that meets the needs of your organization.

## OUR PARTNERS

- \*Health Care Systems:  
Hospitals, Physicians/Providers and  
Managed Care Organizations
- Long-term Services and Supports:  
Medicaid and Medicare
- Community Organizations and  
Providers
- Government and Policy  
Makers



# WHY CHOOSE THE COORDINATING CENTER?

### *Person-Centered*

Personal goals drive The Coordinating Center's approach to helping individuals and caregivers achieve optimal health and independence.

### *Inspires Change*

The Coordinating Center advocates for policy and system change that positively affects the lives of people with the most complex needs.

### *Rich History of Innovation*

Since 1983, The Coordinating Center has translated national movements into ground-level, community-based programs including Transitions of Care, Hospital Encounters including Readmission Reduction, Aging in Place and addressing homelessness.

### *Leaders in Change*

Team members are sought out to serve on national, regional and local initiatives that address disabilities, care coordination, transitions of care, older adults and affordable housing.

### *Qualified Professionals*

The Coordinating Center employs over 250 highly qualified individuals including certified case managers, licensed social workers and nurses, community health workers, housing specialists and supports planners who live in the communities we serve.

### *Driven By Results*

The Coordinating Center is a data driven organization using best practices and evidence-based models to achieve quality outcomes and proven return on investment.

### *Experts in the Field*

The Coordinating Center has been rooted in the community for more than three decades and has access to a wide network of resources.

### *Commitment to Excellence*

The Coordinating Center is accredited by URAC, an independent organization that promotes healthcare quality standards and by the Maryland Nonprofits Standards for Excellence, which ensures accountability and high ethical standards.

### *Widely-Known and Well Respected*

The Coordinating Center is the largest independent, nonprofit community care coordination organization in Maryland and an active leader in healthcare transformation.

### *Partner with Us*

The Coordinating Center provides a customized approach for the most complex populations with public and private payers, hospitals, government and community providers.